ISSN: 3064-8378

Public Policy and Administration Studies Journal

Research Article

BUILDING HEALTHY COMMUNITIES: THE ROLE OF URBAN PLANNING IN PUBLIC HEALTH

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DOI: 10.5281/zenodo.14823427

Abstract

This article delves into the issue of inequity in global healthcare access and emphasizes the importance of interdisciplinary collaboration in healthcare delivery models. It highlights the Healthy Cities model, focusing on the "Healthy Communities" approach by the Centers for Disease Control (CDC). Successful initiatives in public health should prioritize the community as the central unit of analysis. However, many existing studies fail to consider the unique community factors that affect the success of public health endeavors. This article addresses this crucial but often overlooked issue by examining the sustainable development of community health initiatives based on the Healthy Cities model. It specifically investigates the factors that contribute to the successful and sustainable development of such initiatives in various urban environments. The case study of Miami-Dade County serves as an illustrative example. By analyzing secondary sources, observational data, and conducting semi-structured interviews with programmatic leaders and stakeholders, this study reveals a paradigm that can be applied to different settings, aiding in the formulation of successful and sustainable community health initiatives.

Keywords: Healthcare access, Interdisciplinary collaboration, Healthy Cities model, Community health initiatives, Sustainable development

I. Introduction

Inequity in access to affordable and quality healthcare serves as a significant barrier to global health. Various “experiments” in health delivery models have been proposed, and implemented. At the cornerstone of most successful health delivery models is a spirit of interdisciplinary collaboration – one that integrates public health models of delivery within the environment in which it is inevitably deployed. A prime example of such a delivery model is the Healthy Cities model, or dubbed “Healthy Communities” model by the Centers for Disease Control (CDC). These undertakings necessarily examine the delivery of health at the interface of public administration, development, and urban planning. The core, therefore, of such successful initiatives is a fundamental focus on the community as the unit of analysis for public health endeavors. Communities are the ultimate benefactors of most public health proposals, yet much extant literature overlooks the key defining factors of individual communities that impact the success or failure of such public health endeavors.

This article addresses this particularly significant yet overlooked issue through the lens of sustainable development of Healthy Cities based community health initiatives. The key research question addressed here is,

what are the factors that lead to successful, and sustainable, development of community health initiatives in divergent urban environments? To address this question, the municipality of Miami-Dade County is examined. Through analysis of secondary sources, observational data, and semi-structured key informant interviews with programmatic leaders and stakeholders, an emergent paradigm is developed. The results presented herein can be broadly applied to unique environments and assist in crafting successful and sustainable community health initiatives.

Domestically, recent healthcare reform via the Affordable Care Act, places a renewed emphasis on community-oriented, preventive health. Within this regulatory framework, numerous issues arise, such as federalism and shifting administrative burden (Sirpal, 2014). The final focus of this article will be on placing this emerging paradigm within the regulatory framework of modern healthcare reform.

Literature Review

The "Healthy Cities" model for community-based health had its origins in an Ontario conference in 1984. The focus of this conference was on a broader understanding of the determinants of health, aside from individual, patient-specific factors (Ashton, 1986). The formal notion of holistic health promotion took an avant-garde stance, that seemingly external factors, such as the environment, had a key role in shaping individual health. This effort achieved support from largely observational and anecdotal studies that intimated at a key shortcoming of traditional care delivery models. This limitation was the notable paucity of an inquiry into the linkage between environmental factors such as crime, accidents, and pollution, on health (Kenzer, 1999). Fortuitously, that same year, the World Health Organization (WHO) convened the European Healthy Cities Initiative (Hancock, 1993) to indoctrinate the emerging underpinnings of the "new public health". The Ottawa Charter for Health Promotion, a product of this multi-disciplinary and multi-national effort, served as the foundation for the design and implementation of health initiatives that placed the community at the *epicenter* of health care delivery and administration. More than three decades later, this foundation has served as the underpinning of community-based health endeavors worldwide.

Shortly following the memorializing of the Ottawa Charter, the WHO created the *European Healthy Cities Project* (Tsouros, 1990). This project originally began as a pilot study with 11 formally designated cities to nearly 35 within five years of programmatic deployment (Hancock, 1993). The European Healthy Cities Project was envisioned to be adopted in disparate five-year phases, with each phase having its own unique deliverables and anticipated outcomes (Ashton, 1986). Phase 1 of the European Healthy Cities Project (1987-1992) focused on the designing aspect of community health reform. Specifically, this phase highlighted the process-oriented nature of community health (WHO Regional Office for Europe, 1997). Hence, phase 1 sought to identify key disparities in individual community health in order to craft reform and define points for community involvement and intervention (Tsouros, 1990).

Whereas phase 1 focused on individual community factors and defining specific disparities within the communities, phase 2 sought to integrate community stakeholders in governing and shaping public health policy (WHO Regional Office for Europe, 1997, p.4). This integration served to ensure that community-based health efforts existed as a part of, and not separate from, the larger framework of public health policy. This is a key aspect of the success of the European Healthy Cities Project, and one which jumpstarted the creation of an unified international network of municipal-based health efforts (Kenzer, 1999). Key to this effort was not only that it led to a unified voice in advancing holistic health, but it also served as fertile grounds for an evidence-based inquiry into "smart" community health initiatives.

Whereas phase 2 aggrandized the role of individual community efforts within the broader health policy framework, phase 3 soughtto strengthen the network base of similarly situated community health endeavors. The original European Healthy Cities project envisioned four conditions precedent in order for inclusion within an existing "community health network":

1) clear political buy-in;
2) presentation of an effective plan to improve municipal health;
3) existing infrastructure; and
4) Committed to aligning efforts as a network.

By and through this network-strengthening approach, phase 3 memorialized the evaluative criteria for community-based health initiatives, i.e., the tripartite goals of bridging the gaps in delivery of care, forwarding social development, and ensuring the *sustainability* of community development. Phase 4 then focused on the creation of an inter-disciplinary comprehensive municipal health plan.

This phase is of utmost interest, as it harmoniously integrates urban planning, public administration, and public health via its call to address community health equity in all local policies, supported by three fundamental tenets - "caring and supporting environments; healthy living; and healthy urban environments and design"(WHO Regional Office for Europe, 2009).

Inasmuch as the WHO-based European Healthy Cities Project and the thematic guidelines for successful implementation have been replicated across the globe, although the original project still is strongest in Europe. Inasmuch as community based health endeavors have since experienced burgeoning growth globally, the fundamental tenets of these initiatives have been built on the WHO model. Experiments in transplanting the European model to Africa and South East Asia have experienced mixed results. A root-cause analysis of the failure of those initiatives has attributed such largely to, *inter alia*, a paucity of formal health networks in existence, ineffective or poorly implemented health policy frameworks, lacking infrastructure and/or resources, and inadequate / insufficient funding.

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I. "Healthy Cities" Defined

An inquiry into the relative successes of initiatives modeled after the "Healthy Cities" movement indubitably requires strict operationalization of the Healthy Cities concept. Scholars have defined a "healthy" city as:

"…[a healthy city is] one that is continually creating and improving those physical and social environments and strengthening those community resources which enable people to mutually support each other in performing all the functions of life and achieving their maximum potential" (Hancock and Duhl, 1986, cited in Hancock, 1993, p.7).

For the purposes of this analysis, therefore, a healthy city is one which first and foremost, places an emphasis of the municipality, township, or other "community" as the epicenter of healthcare administration. This frames the unit of analysis for assessing the impacts of various public health initiatives studied. Furthermore, the emphasis on the "city" necessarily calls for neighborhood factors to be systematically addressed in evaluating the success of a public health initiative – insofar as community and population-based health is concerned (Kenzer, 1999, p.201).

A second, but equally important aspect of the operationalization of the "Healthy Cities" concept is that the political meaning of a "city" is applicable to any analysis of a community-based public health initiative (Hancock, 1993). Undoubtedly, the success of any community-based initiative will require political buy-in by the local government, and this commitment will be essential for the longevity, and presumably, the success, of any public health initiative. In the context of recent legislative tides in healthcare reform, e.g., the Affordable Care Act, this political dimension is even stronger given the wider shift toward urbanization, decentralization, and local administration of public health initiatives (Sirpal, 2014; van Naerssen and Barten, 2002).

Next, a third aspect that is crucial in this analysis is that the "municipality" is scrutinized through an ecological perspective, whereby the contextual aspects of the neighborhood itself are assessed as integral components of the public health initiative. In this manner, the "Healthy City" examines health as an integrated network-like system that depends on the opposite operations of each of its components (Ashton et al, 1986; Duhl, 1986). The corollary to this means of analysis is that the homeostatic mechanisms of each individual community continually adapt to meet the dynamic health needs of the populace (Duhl, 1986). This lends itself to a process-oriented, as opposed to an outcome-oriented perspective in crafting, implementing, and legitimizing sustainable health initiatives (Sirpal, 2014, Hancock, 1993).

A fourth layer of this analysis is that an understanding of the "health" of a city must necessarily subsume traditionally "non-health" elements. The conventional understanding of health, i.e., freedom from illness and the spectrum of a scope of well-being, is far too limiting for this analysis. Hence, other factors such as, *inter alia*, schools, green spaces, the built environment, housing, accessibility to quality food sources, all fall under the gambit of community "health" determinants (Kickbusch, 2007). This holistic and encompassing framework seeks

to draw a multi-disciplinary assessment of "everything that impinges on the human being" (Duhl, 2005, p.358), with the caveat that the human being of interest resides in a microcosm, that is, the community and/or city.

Hence, the "healthy city" model as operationalized here, assesses the multi-faceted social, economic, urban, and environmental determinants of health. This undertaking is symptomatic of a broader focus on the underpinnings of public health – a shift in the focus of health promotion from individual risk-factor modification to understanding the overall contextual meaning of healthy lifestyles and the social determinants of population health (Kickbusch, 2003, p.383). Therefore, the model studied herein examines community health at the confluence of urban policy development, decentralization practices, and public administration (van Naerssen and Barten, 2002, p.10).

Given the focus on processes that shape public health in a local context, the Healthy Cities movement has broad applicability that overshadows public health research that has traditionally myopically focused on specific policy prescriptions (Sirpal, 2014 and Werna et al, 1999). Inasmuch as the Healthy Cities model focuses on the role of the community in individual health, it also emphasizes individual autonomy and decision-making, in transforming their lifestyles (Kenzer, 1999). The approach taken by the Healthy Cities model, therefore effectively empowers individuals – transplanting the movement toward participatory governance into the community health context (Duhl, 2005; Sirpal, 2014; van Naerssen and Barten, 2002; Leeuw, 2009).

II. The "Healthy Cities" Model as a Proactive Health Model

The notion of community-based involvement in promoting healthy lifestyles is aligned with the goals of the modern American healthcare system. In fact, a Quality Chasm report of the Institute of Medicine (IOM) depicts an American health care system riddled with needs for drastic changes in infrastructure, revision in incentives for health promotion, and development of policy that addresses the needs of millions of patients who require collaborative quality care management to effectively prevent and manage chronic diseases, such as diabetes, hypertension, and hyperlipidemia. The realization that public policy must inevitably address these issues has led to the parallel development of economically-efficient interventions that can effect change in health behavior.

The Healthy Cities model, by definition, places a premium on preventive health. Indeed, recent revisions in the infrastructure of the US healthcare system are predicated on the foundation that while self-responsibility underlies the core of individual health, the survival of the healthcare system depends on collaboration. Such collaborative spirit fosters mutual accountability for health and underscores the integral involvement of community players, healthcare providers, and individuals in assuring health care. From an economic perspective, encouraging and fostering healthy behavior has an added incentive: it reduces health costs and fosters enhanced productivity. In addition to the potentially global benefits of health promotion by alleviating and offsetting the burden of chronic disease, there is a well-substantiated link between community wellness, especially among children, and safe, healthy communities.

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The modest, guarded successes of community-based incentives for health promotion, however, are overshadowed by their several limitations. For instance, short-term lifestyle modification is insufficient to effect longlasting healthy behavioral changes unless stepwise improvements in well-being are fostered continually. This underscores the importance of creating a sustainable healthy community that would be capable of fostering such permanent lifestyle changes. Further, although fleeting positive health outcomes may initially improve individual health, should patients be unable to reach health goals, and thereby suffer financial and health consequences, health providers will inevitably be treating poorly compliant patients with chronic health conditions. Indeed, successful community-based health promotion programs are those that are both sufficient in substantive value and those that do not encourage only superficial behavioral change.

III. Miami in Context

Miami has its challenges in making health equitable to all. It has been considered one of the most impoverished and medically underserved communities in North America. At the epicenter of focus within Miami is the community of Liberty City. Liberty City is a neighborhood in Miami, Florida, roughly bound by NW 79th Street to the north, NW 27th Avenue to the west, Northwest 54th Street to the South, and Interstate 95 to the east. Liberty City is home to one of the largest concentrations of African Americans among urban cities in the State of Florida, and is the most medically underserved urban community in South Florida. A history of failed community-based health initiatives in Liberty City makes it an ideal focus of a study on the challenges to implementation of complex urban health initiatives.

Community health initiatives in Liberty City, such as the Miami Children's Initiative (MCI), have been modeled after the Healthy Cities initiative, and have endeavored to transform health care delivery in Liberty City. Far too often, however, the implementation of such programs suffers from a lack of consideration of the multitude of the other factors that impact health, i.e., concentration of low-income housing projects, the flight of the area's businesses, increased joblessness, low performing schools, growing poverty, crime, juvenile delinquency, drugs and poor health.

The MCI was initially known as the "10-year Magic City Children's Zone, "created in 2008 by Florida Legislative act. It was renamed in 2009 as the MCI, and has retained its focus on engendering a community-based consortium of stakeholders in health, human services, and education. Through extensive planning — professionally facilitated via 43 work groups and 18 focus groups — MCI crafted a plan and strategy to achieve progress toward a "prosperous Liberty City." Since 2009, however, the MCI has enjoyed limited successes. The focus of this inquiry will be to shed light on possible solutions to making community health initiatives work in complex urban landscapes, such as Liberty City. This undertaking is timely, especially in light of efforts to promote the economic and public health development of Liberty City. This work will define practical solutions for implementation of

health initiatives, with the ultimate goal of developing novel paradigms for implementation in diverse urban environments.

Methods

Data collection instruments and measures

The objective of this study, i.e., understanding the enablers and barriers to successful, and sustainable, implementation of the Healthy Cities model in complex North American urban environments, were accomplished via quantitative and rigorous qualitative techniques. Specifically, the research goals are amenable to qualitative inquiry. Indeed, qualitative investigation of the successes of community health initiatives has the potential to identify other possible causal relationships that may be operating to influence the success or failure of such healthy cities initiatives.

In order to effectively design the qualitative study, the quality guidelines of qualitative research as espoused by White and Adams (1994) were adhered to. Specifically, through analysis of secondary sources, observational data, and semi-structured key informant interviews with programmatic leaders and stakeholders, an emerging paradigm is presented. This methodology allows for a better understanding of implementation of such initiatives and potential ways of addressing challenges. Qualitative data are particularly useful for understanding processes (such as implementation of new policies and protocols) because they would permit the researchers to probe in greater detail than is possible in surveys (Maxwell, 2008).

The first arm of the proposed qualitative research strategy entailed extensive review of secondary sources, such as newspapers, reports, and photographs. This allowed for a detailed examination of raw materials of the recent or more distant past to gain insights for both methodological and theoretical purposes. Next, an in-depth case study of the City of Miami, and more particularly, Liberty City, was conducted to examine specific municipalities to hopefully better understand other possible causal relationships that may be operating to influence success or failure of community health initiatives or to suggest mechanisms by which environmental or contextual factors affect success and sustainability (Bailey, 1992).

Case study research excels at bringing us to an understanding of a complex issue or object and can extend experience or add strength to what is already known through previous research. Case studies emphasize detailed contextual analysis of a limited number of events or conditions and their relationships. Researchers have used the case study research method for many years across a variety of disciplines. Social scientists, in particular, have made wide use of this qualitative research method to examine contemporary real-life situations and provide the basis for the application of ideas and extension of methods. Researcher Robert K. Yin defines the case study research method as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used (Yin, 2009).

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In selecting Miami and Liberty City, in particular, as a municipality to study through case study analysis, the following salient characteristics were noted:

- strong community-based health initiatives;
- high percentage population of medically underserved residents;
- those with explicit policies in place insofar as community health initiative policies are concerned; • Those with varying socio-political landscapes insofar as healthcare is concerned; and
- those with varying levels of success on community health initiatives.

These parameters reflect the findings of previous studies assessing the impacts of similar public health initiatives (Bailey, 1992). Another method pursued in this research was semi-structured key informant interviews. Specifically, key informant interviews were conducted with local Miami community health initiative directors, community stakeholders, and community leaders. These interviews provided invaluable data on individual perspectives and permitted the collection of politically sensitive information that would provide important insights and background information. In all interviews, the offer to withhold the names of those interviewed was extended. The key informant interviews with community health leaders and programmatic officials, although semistructured, were guided by certain themes. Specifically, they were thematically guided in such a manner to ascertain the degree to which the successes or failures of community health initiatives were associated with the community's unique characteristics, and the extent to which such success was driven by the policy choices and the political leanings of the local electorate. Furthermore, such methods were instrumental in dissecting the complex politico-social factors playing a role in implementation of such initiatives.

Format of the Interviews

An open –ended interview instrument was developed and used to interview coordinators and/or programmatic staff. Theywere asked to provide a statement of their entity's respective purpose, the goals of the program, the successes and failures of their initiatives, and the challenges that they faced. Staff members were then asked to identify governmental and non-governmental policies that their initiative was able to influence. Since the questions were open-ended in nature, the information obtained was recorded for analysis. Finally, observations were also included in the research design. Specifically, observations were conducted surrounding the implementation process of the community-based public health initiatives, with a special focus on the efficiency, and quality outcomes of programmatic participants (Becker and Geer, 1957). The research design was employed to systematically address the salient issue of the factors influencing success or failure of healthy cities initiatives in a complex urban environment.

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Results and Discussion

I. Magnitude of the Local Health Disparities

The first aim of this endeavor was to systematically ascertain the true magnitude of the health disparity in Miami-Dade County, and in particular, Liberty City. The rationale behind this was to subsequently assess whether the local community-based health initiatives were strategically designed to address those disparities. Liberty City is classified as a Medically Underserved Area/Population (MUA/P ID 06151); a Primary Care Health Professional Shortage Area (PC HPSA ID 1122999122R); and a Dental Care Health Professional Shortage Area (DC HPSA ID 612999121F). As an initial inquiry, baseline non-health data (race, ethnicity, median age, and median household income) were collected for Liberty City and cross-matched to Miami-Dade County overall (Table 1).

Table 1: Demographic Data of Liberty City versus Miami-Dade County on Selected Parameters

	Liberty City	**Miami-Dade County**
Race		
• African-American	94.69 %	19.2 %
• White American	0.59 %	77.6 %
• Other	1.68 %	1.9 %
Ethnicity		
• Hispanic	3.04 %	64.3 %
Median Age		
• Male	25.9 years	36 years
• Female	30.3 years	39 years
Median Household Income	$18,809.87	$40,260.00

Source: U.S. Census Bureau, 2012

From these data, it is evident that there are striking demographic differences discernible among Liberty City, compared to Miami-Dade County overall. Racially, African-Americans comprise 95% of Liberty City residents compared to only approximately 19% of Miami-Dade County residents. Additionally, the median household income in Liberty City is less than half of the same measure in Miami-Dade County overall. These data inform an understanding of the health disparities among Liberty City residents as they are indicators of the apparent socioeconomic gaps. Much of the extant literature on health disparities documents that accessibility to quality care is a significant barrier in medically underserved areas. In particular, not only do urban areas routinely lack availability of quality health assets within the community, but those that do exist, are unobtainable, or burdensome to obtain. This inevitably leads to declining health and perpetuates a cycle that contributes to increased chronic disease burden.

See figure 1.

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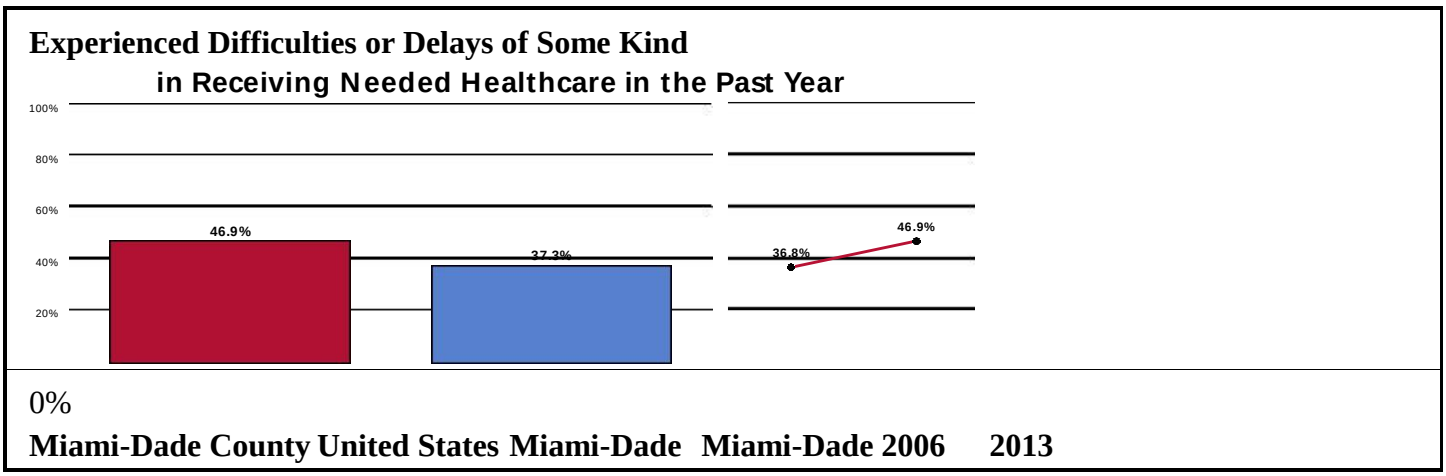

Figure 1: Proportion of Miami-Dade County Residents who Experienced Difficulties Obtaining Necessary Healthcare (versus National averages). Data obtained from: PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 207]. Miami-Dade County residents experienced significantly higher difficulties or delays of some kind in receiving necessary healthcare in the past year as compared to the United States' average (~47% versus ~ 37%). Notwithstanding this, the data for Liberty City are anticipated to be an even more telling portrayal of disparity in access to care.

Next, accessibility to ongoing care was considered. Substantial public health research has evinced that regular, ongoing care is a critical element in preventive medicine. Chronic disease burden, including cardiovascular disease, hypertension, diabetes, and obesity, and their respective sequelae, are all inextricably tied to non-compliance, or lack of access to regular, quality care. See Figure 2.

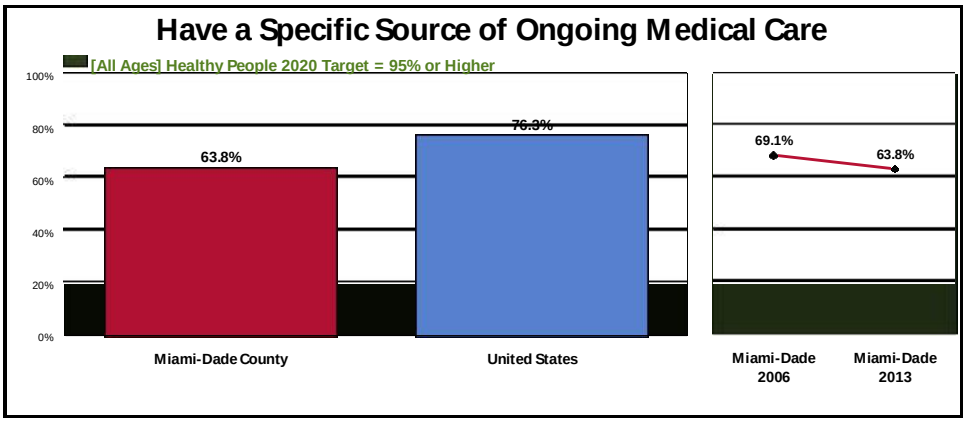

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Figure 2: Proportion of Miami-Dade County Residents who Have a Specific Source of Ongoing Medical Care (versus National averages). Data obtained from: PRC Community Health Surveys, Professional Research Consultants, Inc., 2011.

Miami-Dade County residents significantly lagged behind their national counterparts. Approximately 64% of Miami-Dade County residents had access to a specific source of ongoing medical care to a national average ofapproximately 76%. While the CDC's Healthy People 2020 target is 95% or higher, the magnitude of the problem in Miami-Dade County is significantly worse.

II. Review of Secondary Sources – Establishing the Foundational Basis for Local Health Disparities in Liberty City

Having established the magnitude of the local health and demographic inequities, secondary sources were reviewed in order to contextualize the findings. The history of Liberty City reveals that although nominally termed a "city," it carries more significance and meaning as an 'enclave', i.e., a distinct community formation composed of a spatially segregated demographic and economic formation. Liberty City, and the other historically African-American communities in Miami, such as Overtown and Brownsville, were actually once thriving communities and cultural epicenters. Social strife and a period of civil disturbance in the 1980s left an indelible mark on the community. Today's Liberty City has one of the highest concentrationsof low-income housing projects, increased joblessness, low performing schools, growing poverty, crime, juvenile delinquency, drugs and poor health. Urban sprawl and the flight of the area's businesses left Liberty City and most of its residents, depleted of natural (e.g., green space) and built resources.

These factors have had a direct and significant impact on the availability and accessibility of healthcare. Consequently, this has had an equally strong impact on the effectiveness of any community-based public health initiative deployed in such an environment. The current population of Liberty City is 51, 742 (U.S. Census Bureau, 2012). The health status of Liberty City residents is dismal, with Liberty City residents ranking the highest among residents of other Miami-Dade County communities in terms of sexually-transmitted infections (STI) morbidity. Furthermore, Liberty City residents have a disproportionately higher prevalence of chronic diseases, such as heart disease, cancer, stroke, and diabetes, as compared to other Miami-Dade County residents (PRC Community Health Surveys, 2011). Finally, a survey of the community health assets in Liberty City reveals that there are limited health resources. Namely, the Juanita Mann clinic and the Liberty City Health Center are the two main health centers within the geographic boundaries of Liberty City. The Juanita Mann clinic is an aging facility that has limited resources and both facilities notably lack significant and far-reaching community outreach efforts.

The next phase of the research utilized a two-tiered approach to systematically review secondary data in order to ascertain, 1) the magnitude of the health disparities between Liberty City and the remainder of Miami-Dade County and 2) the population impacts of such inequities. See Table 2.

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Table 2: The 10 Leading Health Concerns in Liberty City as compared to Miami-Dade County

1.	"Fair" or "Poor" Overall Health	30.8% vs. 19.7% countywide
2.	"Fair" or "Poor" Mental Health	17.2% vs. 12.6% countywide
3.	Heart Disease	9.8% vs. 6.2% countywide
4.	Stroke	6.2% vs. 2.0% countywide
5.	High Blood Pressure	42.3% vs. 32.6% countywide
6.	Chronic Lung Disease	10.4% vs. 6.4% countywide
7.	Asthma	9.4% vs. 5.7% countywide
8.	Arthritis/Rheumatism	45.0% vs. 35.6% countywide
9.	Consume Five or More Fruits/Vegetables Daily	32.1% vs. 38.0% countywide
10.	Family Shared Seven or More Meals in the Past Week	52.1% vs. 68.7% countywide

Sources: Data obtained from the PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 207]; 2011 PRC National Health Survey, Professional Research Consultants, Inc.

A significant finding of this two-tiered analysis was thatthe leading health concerns in Liberty City are a telling portrayal of a failure, or utter lack, of appropriate preventive health care/services. Medically speaking, most of the diseases presenting as significant health concerns in Liberty City are chronic diseases that carry significant morbidity as well as are associated with significant costs to the healthcare system.

More strikingly, however, is the second tier of analysis, whereby the prevalence of the same health concern in Liberty City is compared to its prevalence in Miami-Dade County overall. On all indicators, Liberty City experienced a far worse grim health status as compared to county averages. As an added level of analysis, ER admission rates were compared based on GIS data. Admission rates for asthma were considered, especially given the chronic nature of the disease, the high disease burden, the disproportionate impact on the youth, and the high association with environmental factors such as air quality and pollution. See figure 3.

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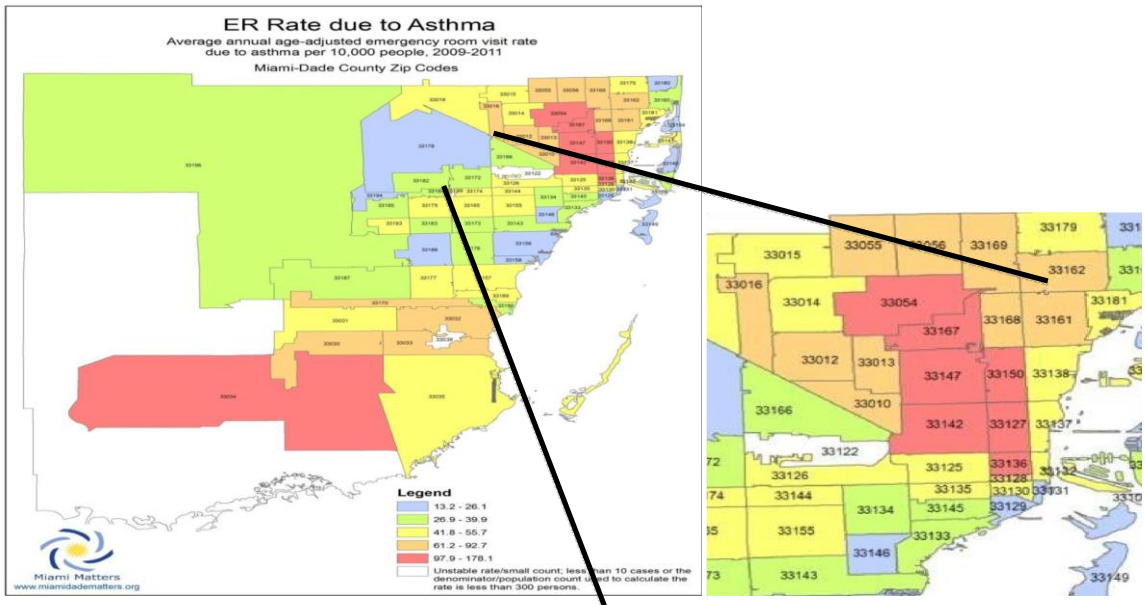

Figure 3: ER Admission Rates for Asthma in a) Miami Dade County with b) expanded version of map section. Note – Zip Codes: 33136 (Overtown), 33127 (Buena Vista), 33128 (Downtown/East Little Havana), 33147 (Liberty City) and 33150 (Little Haiti)

The data show ER admission rates for asthma were the highest in the following zip codes: 33136 (Overtown), 33127 (Buena Vista), 33128 (Downtown/East Little Havana), 33147 (Liberty City) and 33150 (Little Haiti). Given the strong environmental determinants of asthma, these data strongly highlight the importance of consideration of local, community factors, in assessing health. The inextricable link between the environment and health status is wellpresented by this analysis.

III. Community-Based Health Interventions in Liberty City: Semi-structured Interviews with Key Stakeholders

As a final analysis, the demographic (part I) and the thorough review of secondary data (part II) informed the semi-structured interviews with key stakeholders. The objectives of these interviews were to assess 1) what impacts community-based health interventions have made in Liberty City, and 2) what factors have contributed to, or impeded, their success. The results of these interviews revealed that there have been moderate successes of community-based health interventions in Liberty City. Aside from the Miami Children's Initiative (MCI), Miami has another prominent community health initiative, modeled after the Healthy Cities movement.

Miami's Fit2Play program was established in 2005 by the Miami-Dade County Parks and Recreation Department. While not a program directly designed under the principles of the Healthy Cities model, it is a similar community-oriented holistic health initiative for children. The Fit2Play program was largely reactionary in nature, and responded to data showing that Miami-Dade County exceeded the national average in rates of obesity. Specifically, per a report from the Centers for Disease Control and Prevention, the rate of obesity and overweight

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adults in MiamiDade County is 67.4 percent. It cited poor diet and physical inactivity as contributing to the obesity problem, as only 22.1 percent of adults in the county meet the federal government's guidelines for fruit and vegetable consumption.

When asked pointedly why existing programs haven't made significant progress in addressing the grim health status of Liberty City residents (as presented in Parts I and II), stakeholders overwhelmingly responded that the existing programs failed to consider the totality of factors that impact health. Specifically, trends that were observed from the interviews were that programmatic leaders were far often too myopically focused on traditional health factors, while the problem is systemic in nature. Data presented in Parts I and II of this articles further support this notion. The factors identified in the stakeholder interviews contributing to poor health are presented in Figure 4.

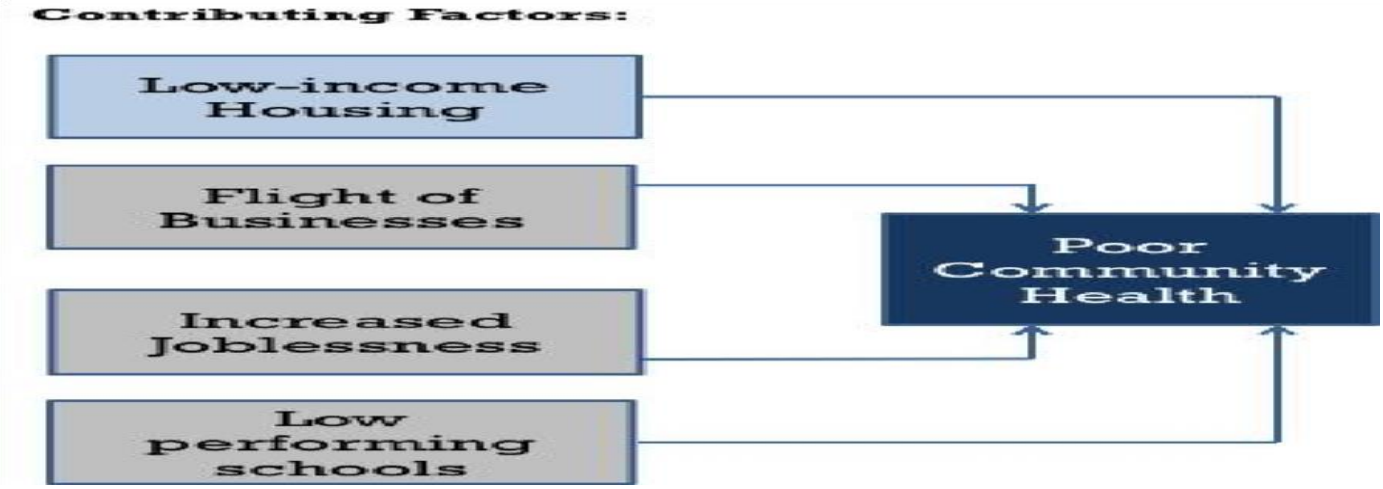

Figure 4: The factors identified in stakeholder interviews contributing to poor health.

As can be discerned from figure 4, the key factors that stakeholders felt were ignored as dominant elements in existing community health initiatives, were traditionally-viewed "non-health" factors. The main factors included low-income housing, the flight of local area businesses, increased joblessness, and low performing schools. All these factors were deemed to be "very important" contributors to the limited successes of existing programs. Additionally, stakeholders suggested that significant progress has been impeded by the inability of existing programs to become effectively integrated within the fabric of the community. This particular defect, was overwhelmingly, touted as tied to the lack of sustainability of programmatic efforts. Furthermore, the lack of effective leveraging of existing resources within the community was identified as a key contributor to the failures of such initiatives.

Stakeholders almost unanimously agreed that there is a strong role for community-based health organizations to play in positively impacting the delivery of public health. There was also agreement that a "healthy cities" model of sorts is the solution, as community elements are quintessentially tied to public health disparities. Additionally,

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all stakeholders agreed that there is substantial funding for such endeavors. However, the ineffectiveness of existing programs was strongly tied to their "transplanted implementation" approach without consideration of the key local factors that truly impacted the public health problem within the community.

Conclusion

Emerging from this research is a novel, exciting paradigm – community-based public health initiatives are not amenable to a one-size fits all approach. There are key, local factors that impact their success, either positively or negatively. See Figure 5. Interestingly, the limited successes of existing programs have been attributed to their notable lack of consideration of key, non-health factors that play significant roles in shaping community health. Community health is multi-faceted anda multi-dimensional phenomenon. No two communities are exactly the same. This renders "healthy cities" programmatic transplants largely prone to failure – either in achieving sustainable change or achieving any positive outcome in the first instance. The overarching theme that emerges is that each individual community must be assessed, its history understood, and the unique opportunities for sustainable public health initiatives must be strategically addressed. For the model to be successful, it has to be grounded in understanding the identified needs, history, and available opportunities.

Figure 5: Emerging Paradigm – Community Health is multi-faceted and depends on several, traditionally viewed "non-health" factors.

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